		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0008300

Facility Name: Elizabeth Nursing Home

Address: 540 Pleasant Street (Number) Elizabeth (City) 61028 (Zip Code)

County: JoDaviess

Telephone Number: (815) 858-2275 **Fax #** (815) 858-2596

IDPA ID Number: 36-2650434

Date of Initial License for Current Owners: 07/01/1968

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		x	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: James Harkness **Telephone Number:** (815) 858-2275, ext. 28

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) 03/25/05 (Date)
(Type or Print Name) James Harkness
(Title) Administrator

Paid Preparer
(Signed) 03/24/05 (Date)
(Print Name and Title) Gwen A. Moser, CPA, Senior Manager
(Firm Name & Address) Eide Bailly LLP, 3999 Pennsylvania Ave., Suite 100, Dubuque, IA 52002
(Telephone) (563) 556-1790 Fax # (563) 557-7842

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	49	Intermediate (ICF)	49	17,934	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	49	TOTALS	49	17,934	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	6,719	9,482		16,201	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,719	9,482		16,201	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.34%

D. How many bed-hold days during this year were paid by Public Aid?
6 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Assisted Living Facility

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 07/08/1968

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	126,546	7,558	4,040	138,144	(32,535)	105,609		105,609			1
2	Food Purchase		78,759		78,759		78,759	(4,583)	74,176			2
3	Housekeeping	39,225	10,821		50,046		50,046		50,046			3
4	Laundry	26,659	3,403		30,062		30,062		30,062			4
5	Heat and Other Utilities											5
6	Maintenance	23,954	25,200	42,093	91,247	(2,232)	89,015		89,015			6
7	Other (specify):*											7
8	**TOTAL General Services**	216,384	125,741	46,133	388,258	(34,767)	353,491	(4,583)	348,908			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	539,556	35,683	4,855	580,094	1,270	581,364		581,364			10
10a	Therapy											10a
11	Activities	32,628	2,017	450	35,095		35,095	(2,179)	32,916			11
12	Social Services	23,451		450	23,901		23,901		23,901			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	595,635	37,700	5,755	639,090	1,270	640,360	(2,179)	638,181			16
	C. General Administration											
17	Administrative	70,414	70,472		140,886	(28,172)	112,714	(4,470)	108,244			17
18	Directors Fees			6,750	6,750		6,750		6,750			18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions											20
21	Clerical & General Office Expenses											21
22	Employee Benefits & Payroll Taxes			226,442	226,442	(27,084)	199,358		199,358			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			70,048	70,048	(14,010)	56,038		56,038			26
27	Other (specify):*											27
28	**TOTAL General Administration**	70,414	70,472	303,240	444,126	(69,266)	374,860	(4,470)	370,390			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	882,433	233,913	355,128	1,471,474	(102,763)	1,368,711	(11,232)	1,357,479			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Elizabeth Nursing Home #0008300 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			67,034	67,034	(31,335)	35,699	(21)	35,678			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			94	94		94	(94)				32
33	Real Estate Taxes			26,546	26,546	(14,275)	12,271		12,271			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			93,674	93,674	(45,610)	48,064	(115)	47,949			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					26,902	26,902		26,902			42
43	Other (specify):* **Assisted Living**	116,116	22,384	15,800	154,300	121,471	275,771		275,771			43
44	**TOTAL Special Cost Centers**	116,116	22,384	15,800	154,300	148,373	302,673		302,673			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	998,549	256,297	464,602	1,719,448		1,719,448	(11,347)	1,708,101			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,872)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(3,761)	17		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,711)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(358)	17		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(351)	17		28
29	Other-Attach Schedule	(2,294)	11		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (11,347)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (11,347)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Elizabeth Nursing Home

ID# 0008300

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Machine Income	$ (2,179)	11	1
2	Equipment Depreciaiton adjustment	(21)	30	2
3	To offset interest expense due to excess borrowing	(94)	32	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(2,294)		49

ELIZABETH NURSING HOME #0008300 Y/E 12/31/04

COST REPORT RECLASSIFICATIONS		FROM	TO
1 Reclass IDPA Participation Fees -	26,902	**L17**	**L42**
2 Reclass Contracted Nsg (temp. services) -	1,270	**L17**	**L10**
3 Reclass certain unassigned expenses to Assisted Living Facility: (most are g/l a/c #'s)			
Property taxes	14,275	**L33**	**L43**
Employee Benefits, uniform payment, etc.	27,084	**L22**	**L43**
Other Insurance	14,010	**L26**	**L43**
Depreciation	31,335	**L30**	**L43**
Dietary	32,535	**L01**	**L43**
Repairs / Maintenance	2,232	**L06**	**L43**

(Note: Housekeeping expense per the G/L is only for the Nursing Home. The homemakers, whose salaries are posted directly to Assisted Living, do housekeeping in the ALU area.

ELIZABETH NURSING HOME #0008300 Y/E 12/31/04

COST REPORT ADJUSTMENTS

1	To off-set nonpatient meals (G/L #0331 and #4999)	**1,872**	**L2,C7**
2	To off-set misc. income (G/L #0333)	**3,761**	**L17,C7**
3	To off-set sales tax on food for non-Public aid resident days		
	NH food costs 78759 X 6.25% X 9,482 Non-PA days =	**2,711**	**L2,C7**
	1.0625 16,201 Total days		
4	To off-set non-allowable advertising, public relations, etc.		
	Public relations	**308**	
	Elizabeth Chamber of Comm. Dues	**50**	
	Yellow Page advertising	**351**	
		709	**L17,C7**
5	To off-set vending machine income (G/L #0332)	**2,179**	**L11,C7**
6	To deduct equipment depreciation for 2002 additions when accelerated method was used	**21**	**L30,C7**
7	To off-set interest expense due to excess borrowing (G/L #0625-000)	**94**	**L32,C7**

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Elizabeth Nursing Home # 0008300 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,583)	0	0	0	0	0	0	0	0	0	0	(4,583)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,583)	0	0	0	0	0	0	0	0	0	0	(4,583)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(2,179)	0	0	0	0	0	0	0	0	0	0	(2,179)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(2,179)	0	0	0	0	0	0	0	0	0	0	(2,179)	16
	C. General Administration													
17	Administrative	(4,470)	0	0	0	0	0	0	0	0	0	0	(4,470)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(4,470)	0	0	0	0	0	0	0	0	0	0	(4,470)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(11,232)	0	0	0	0	0	0	0	0	0	0	(11,232)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Elizabeth Nursing Home** **#** **0008300** **Report Period Beginning:** **01/01/04** **Ending:** **12/31/04**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(21)	0	0	0	0	0	0	0	0	0	0	(21)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(94)	0	0	0	0	0	0	0	0	0	0	(94)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(115)	0	0	0	0	0	0	0	0	0	0	(115)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(11,347)	0	0	0	0	0	0	0	0	0	0	(11,347)	45

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [x] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Darlene Read	Shareholder	Board Member	0.04	0	1.5	0.04	Dir. Fees	$ 1,100		1
2	Penny Heidenreich	Shareholder	Board Member	0.01	0	1.5	0.04	Dir. Fees	500		2
3	Nancy Walker	Shareholder	Board Member	0.01	0	1.5	0.04	Dir. Fees	1,050		3
4	Jack Graves	Shareholder	Board Member	0.03	0	1.5	0.04	Dir. Fees	400		4
5	Marvin Wurster	Shareholder	Board Member	0.04	0	1.5	0.04	Dir. Fees	750		5
6	Ken Haas	Shareholder	Board Member	0.01	0	1.5	0.04	Dir. Fees	600		6
7	Ted Krohmer	Shareholder	Board Member	0.01	0	1.5	0.04	Dir. Fees	600		7
8	Wayne Trost	Shareholder	Board Member	0.01	0	1.5	0.04	Dir. Fees	600		8
9	Carol Rayhorn	Shareholder	Board Member	0.03	0	1.5	0.04	Dir. Fees	550		9
10	James Harkness	Administrator	Administrator	0.00	0	40	100.00	Dir. Fees	600		10
11	James Harkness	Administrator	Administrator	0.00	0	40	100.00	Compensation	56,471		11
12											12
13								TOTAL	$ 63,221		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [x]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Alliant Energy Loan		x	Energy Efficient Lights in NH	$332.00	02/25/00	$ 18,471	$ 991	03/31/05	0.0301	$ 94	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$332.00		$ 18,471	$ 991			$ 94	9
	B. Non-Facility Related*											
10	Assisted Living Apartments		x	Financing 1998 Addition	$16,732.00	05/02/03	387,759	277,234	02/01/2010	0.0575	15,800	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related				$16,732.00		$ 387,759	$ 277,234			$ 15,800	14
15	TOTALS (line 9+line14)						$ 406,230	$ 278,225			$ 15,894	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.	$	26,800	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	26,546	2
3. Under or (over) accrual (line 2 minus line 1).	$	(254)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	26,800	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	26,546	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	28,081	8
	2000	27,676	9
	2001	26,980	10
	2002	26,284	11
	2003	26,546	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Elizabeth Nursing Home COUNTY JoDaviess

FACILITY IDPH LICENSE NUMBER 0008300

CONTACT PERSON REGARDING THIS REPORT James Harkness

TELEPHONE (815) 858-2275 FAX #: (815) 858-2596

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	07-002-348-06	S25 T27 R2E PT NE NE	$ 26,546.46	$ 12,271.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 26,546.46	$ 12,271.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? x YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 25,048 B. General Construction Type: Exterior Masonary Frame _____ Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1967	$ 1,055	1
2			1985		2
3	TOTALS			$ 1,055	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	49				$	$		$	$	$	4
5											5
6			1985	1985	151,186	7,295	16	7,295			6
7											7
8											8
	Improvement Type**										
9	Improvements			1973	1,937					1,937	9
10	Improvements			1968	90,793					90,793	10
11	Improvements			1969	1,546					1,546	11
12	Improvements			1975	2,644					2,644	12
13	Improvements			1976	2,482					2,481	13
14	Improvements			1977	7,295					7,295	14
15	Improvements			1978	7,159					7,159	15
16	Improvements			1980	6,261					6,261	16
17	Land Improvements			1986	3,143	165	19	165		3,029	17
18	Land Improvements			1988	850		15			850	18
19	Smoke detectors			1981	603					603	19
20	Roof			1982	11,431					11,431	20
21	Windows			1983	5,131					5,131	21
22	Windows			1984	9,124		18			9,124	22
23	Vent Control			1985	3,837	134	19	134		3,837	23
24	Door/Wall guards			1986	1,817	96	19	96		1,796	24
25	Roof Htr & AC			1987	5,473	174	31.5	174		3,005	25
26	Land Improvements			1990	5,345	356	15	356		5,092	26
27	Windows/Service Door			1988	13,338	423	31.5	423		6,974	27
28	Roof Htr & AC			1989	8,448	268	31.5	268		4,052	28
29	Roof (East, West & North)			1990	49,329	1,566	31.5	1,566		22,055	29
30	Roof Well Decks			1992	8,194	260	31.5	260		3,251	30
31	Remodel Computer Room			1992	5,872	186	31.5	186		2,327	31
32	Center structure roof			1996	7,950	204	39	204		1,665	32
33	So. Wing Htg. & AC Unit			1997	4,160	298	7	298		4,160	33
34	Kitchen Remodeling			1997	22,802	577	39.5	577		4,330	34
35	Exterior Remodeling			1997	20,031	507	39.5	507		3,804	35
36	26 Toilets			1997	8,443	603	7	603		8,443	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	New Nursing Hm hand rail	1998	$ 8,483	$ 215	39.5	$ 215	$	$ 1,396	37
38	Cast Iron tub base	1998	1,482	38	39.5	38		244	38
39	Nursing Hm Addition (Lndry & Bus. Office)	1998	97,742	2,474	39.5	2,474		16,084	39
40	Land Improvements - NH	1998	2,258	133	15	133		1,125	40
41	Landscaping - NH	1999	1,185	74	15	74		520	41
42	Screen door system	1999	425	11	39.5	11		59	42
43	Install 14M BTU Htg & AC roof top unit	2000	3,824	98	39	98		437	43
44	Energy Eficient Lighting - NH	2000	12,431	319	39	319		1,421	44
45	Outside Lighting - NH	2000	1,190	31	39	31		136	45
46	Land Improvements - NH	2001	2,290	153	15	153		534	46
47	Koehler Utility Sink	2002	667	117	7	117		375	47
48	Tile Project (Nursing Home Dining Area	2003	2,113	67	31.5	67		101	48
49	AO Smith Holding Tank	2004	1,324	189	7	189		189	49
50	Ceiling Lights - N.H.	2004	484	1	31.5	1		1	50
51	Flooring - Nurses station area	2004	2,322	3	31.5	3		3	51
52	Suspended Ceiling - N.H. Hallway	2004	4,765	6	31.5	6		6	52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 609,609	$ 17,041		$ 17,041	$	$ 247,706	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 121,851	$ 15,804	$ 15,804	$		$ 76,053	71
72	Current Year Purchases	8,586	688	688			688	72
73	Fully Depreciated Assets	228,489	2,166	2,166			228,489	73
74								74
75	TOTALS	$ 358,926	$ 18,658	$ 18,658	$		$ 305,230	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 969,590	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 35,699	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 35,699	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 552,936	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Building Imp - Assisted Living	$ 1,088,446	$ 27,556	$ 186,001	86
87	Land Imp - Assisted Living	5,150	304	2,565	87
88	Appliances/Furn. - Assisted Living	24,331	3,476	22,593	88
89					89
90					90
91	TOTALS	$ 1,117,927	$ 31,336	$ 211,159	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elizabeth Nursing Home # 0008300 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/04 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,769	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	47,269		3
4	Supply Inventory (priced at)	4,402		4
5	Short-Term Investments	235,706		5
6	Prepaid Insurance	23,181		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Deferred income tax bene.	13,914		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 327,241	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,275		13
14	Buildings, at Historical Cost	1,553,900		14
15	Leasehold Improvements, at Historical Cost	149,303		15
16	Equipment, at Historical Cost	383,257		16
17	Accumulated Depreciation (book methods)	(915,280)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,176,455	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,503,696	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 29,774	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	55,547		29
30	Accrued Salaries Payable	76,945		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,606		31
32	Accrued Real Estate Taxes(Sch.IX-B)	26,800		32
33	Accrued Interest Payable	2,469		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Income taxes payable	11,485		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 212,626	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	222,678		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred income taxes	9,237		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 231,915	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 444,541	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,059,155	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,503,696	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,010,288	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,010,288	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	59,967	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(11,100)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 48,867	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,059,155	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,766,764	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,766,764	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	2,179	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,872	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	3,761	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 7,812	23
	D. Non-Operating Revenue		
24	Contributions	12,377	24
25	Interest and Other Investment Income***	6,978	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 19,355	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,793,931	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	388,258	31
32	Health Care	639,090	32
33	General Administration	444,126	33
	B. Capital Expense		
34	Ownership	93,674	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37	Assisted Living Facility	154,300	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,719,448	40
41	**Income before Income Taxes (line 30 minus line 40)****	74,483	41
42	**Income Taxes**	(14,516)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 59,967	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 36,319	$ 17.46	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,896	5,417	82,025	15.14	3
4	Licensed Practical Nurses	8,367	8,957	125,055	13.96	4
5	Nurse Aides & Orderlies	32,578	34,231	311,471	9.10	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,207	2,283	20,506	8.98	9
10	Activity Assistants	1,330	1,407	11,758	8.36	10
11	Social Service Workers	1,994	2,162	23,451	10.85	11
12	Dietician					12
13	Food Service Supervisor	2,135	2,303	27,487	11.94	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,903	11,237	99,058	8.82	15
16	Dishwashers					16
17	Maintenance Workers	2,064	2,232	23,953	10.73	17
18	Housekeepers	4,377	4,719	42,263	8.96	18
19	Laundry	3,191	3,368	27,864	8.27	19
20	Administrator	2,080	2,080	56,470	27.15	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,333	1,441	17,515	12.15	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Assisted Living	9,098	9,566	120,094	12.55	33
34	TOTAL (lines 1 - 33)	88,633	93,483	$ 1,025,289 *	$ 10.97	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	96	$ 4,781		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	4	209		38
39	Pharmacist Consultant	125	3,600		39
40	Physical Therapy Consultant	20	580		40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	12	625		44
45	Social Service Consultant	12	625		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	269	$ 10,420		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	280	2,543		52
53	TOTAL (lines 50 - 52)	280	$ 2,543		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elizabeth Nursing Home **#** 0008300 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IHCA dues of $2,646

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 5.34

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ None Line N/A

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. N/A

(9) Are you presently operating under a sublease agreement? _____ YES x NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 26,902
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ None Has any meal income been offset against related costs? Yes Indicate the amount. $ 1,872

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Eide Bailly LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Elizabeth Nursing Home
Book - Tax Reconciliation
12/31/2004

Income before income taxes (page 19)	74483
Accrued Vacation Adjustment	3830
Contributions received	-12377
Depreciation adjustment	-3138
Federal Taxable Income per tax return	62798